MIRROR MIRROR
BEAUTY BOUTIQUE

Name _____ Sex: Male / Female Date _____
(as it appears on your government issued ID)

Address _____

City _____ State _____ Zip _____

Cell Phone _____Home Phone _____Other _____

Date of Birth _____ Email Address _____

Emergency Contact Name_____ Phone _____ Relationship_____

How were you referred? _____

What are your overall skin and body concerns & goals?

_____

Dermatologist in the past year? Yes No If yes, why? _____ Last Physical? _____

Weight: _____ Height: _____ Ethnic background? _____(for skincare analysis only)

How is your general health? Excellent Good Fair Poor

Smoke: Yes No How many per day? ____ Alcohol: Yes No How often? _____ Per Day? ____

Please circle the following conditions or treatments that you have/had or experienced.

Hypertension/ Anxiety	Cold Sores	Anemia	Cancer / Cancer Treatments	HIV	Hepatitis
Headaches	Fainting	Metal Implants	Lupus	Thyroid Disorders	Pace Maker
Asthma	Claustrophobia	Epilepsy / Seizures	Diabetes	Hernia / Hernia Repair	IVF
Heart Problems	Raynaud's Disease	Cold Uticaria	Pregnancy /Breast Feeding	Hormone Imbalance	Nerve Disorder
Sensitive / Sensitized Skin	High / Low Blood Pressure	Accutane Treatment	Auto Immune Disorder – What Kind?	Other:	

Please list any medication, herbs, nutritional supplements or birth control implants.

_____

Allergies

Do you have any known allergies? Yes No Unknown

If yes, please explain. _____

Are you currently having skin treatments? Yes No

If yes, what type of treatment(s)? _____

Please circle if you have or have you had any of the following in the last 14 days.

Facial Cosmetic Surgery	Botox Injections	Extractions	Collagen Injections	Permanent Cosmetics	Fillers
Light Treatments	Chemical Exfoliation (Peels)	Waxing	Laser Hair Removal	Laser Resurfacing	Microdermabrasion /Leveling

Please circle if you are presently experiencing or have experienced in the past.

Keloid Scarring	Skin Cancer	Broken Capillaries	Acne	Dermatitis or Rash	Treatment Reactions
Hypo/ Hyperpigmentation	Skin Care Products Reaction	Rosacea/ Redness	Sensitivities	Other:	

Home Care

Please circle the skincare products are you currently using at home.

Cleanser Serums Toner Exfoliants/Scrubs Moisturizer Specialty Products SPF Mask

Benzoyl Peroxide (BP) Glycolic Acid (AHA) Lactic Acid (AHA) Resorcinol Salicylic Acid (BHA)

Sulfur Vitamin C Hydrocortisone (HC) Hydroquinone (HQ) Eye Products Topical Antibiotics

Tretinoin (Retin A, Retin-A Micro, Renova, Avita) Adepalene (Differin) Azelaic Acid (Azelex , Finacea)

Tazarotene (Tazorac) Isotretinoin (Accutane) Triluma Metrogel

Other_____

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Sun Protection

Do you use a sunscreen? Yes No If yes, What level of protection? _____ Mineral Based? Y / N

Do you sunbathe, tan in a tanning bed or participate in outdoor activities? Yes No

Have you had any direct unprotected sun exposure in the last 10 days? Yes No

When exposed to the sun do you? (please circle one)

Always burn Never burn Sometimes tan Sometimes burn

What skin conditions do you want to improve? (please circle all that apply)

Acne/Breakouts	Rosacea /Redness	Facial / Body Scarring	Uneven Tone	Hyperpigmentation
Freckles/ Age Spots Sun damage	Enlarged Pores	Dehydration	Uneven Texture	Oiliness
Excess Fat	Saddle Bags	Stretch Marks	Loss of facial volume	Sagging skin
Hypopigmentation	Fine Lines/Wrinkles	Lip lines	Lip volume	Veins face / body
Dryness	Raised Lesions	Other:		

Body Contouring (if applicable)

What areas of your body would you like to improve and reduce volume? _____

Have you had surgical or non-surgical body contouring before? Yes No When? _____

What did you have done? _____

Additional Information

Do you have tattoos in areas of treatment concern (even if skin colored and/or white)

Is there any other necessary information your skincare specialist should know before beginning your treatment?

If so, please explain. _____

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I_____ hereby irrevocably consent to and authorize the use and reproduction by Vitenas Cosmetic Surgery/ Mirror Mirror Beauty Boutique and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken by Vitenas Cosmetic Surgery/ Mirror Mirror Beauty Boutique, or that Vitenas Cosmetic Surgery/ Mirror Mirror Beauty Boutique has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the Vitenas Cosmetic Surgery/ Mirror Mirror Beauty Boutique website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of Vitenas Cosmetic Surgery/ Mirror Mirror Beauty Boutique.
I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.
I hereby release, discharge and agree to hold harmless Vitenas Cosmetic Surgery/ Mirror Mirror Beauty Boutique and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date:_____ Printed Name: _____
Signature: _____

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education.

Date:_____ Printed Name: _____
Signature: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Signature _____ Date _____

CANCELLATION AND RESCHEDULING POLICY

Mirror Mirror Beauty Boutique has a 24-hour cancellation and rescheduling policy for consultations. If you cancel or reschedule your consultation appointment with less than a 24-hour notice or fail to be here for your appointment, $100 will be charged to the credit card on file.

Mirror Mirror Beauty Boutique's cancellation policy exists out of respect for the patients as well as our providers. Cancellations with less than 24-hour notice do not allow other patients the opportunity to schedule an appointment during that time.

A 25% non-refundable deposit is required in order to schedule a treatment. We require a notification of at least 48 hours in order to reschedule your treatment appointment at no cost. If your appointment is cancelled within 48 hours or you arrive more than 30 minutes late to a treatment, the 25% deposit will be forfeited. Treatment fees are payable in full on the first scheduled date of service.

By signing below, you acknowledge that you have read and understand the cancellation/rescheduling policy for Mirror Mirror Beauty Boutique as described above.

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I also understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. I hereby release Mirror Mirror Beauty Boutique from any liability pertaining to treatments, understanding that results cannot be guaranteed due to individual skin and body type(s) and condition(s).

Patient Printed Name _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Children

In order to ensure the safety of children and the enjoyment of all guests, we ask that parents or guardians make other arrangements for children, as we cannot accommodate them during your visit. This allows everyone involved in the appointment to give you the attention you deserve.

Pets

Only Working Service Dogs Permitted

For the health and safety of our patients, Mirror Mirror Beauty Boutique has a No-Pets policy.
Although we love animals, we ask that you please leave your pet at home during your visit.

This No-Pets policy applies to:

- Pets
- Emotional Support Animals
- Comfort Animals
- Therapy Animals

Mirror Mirror complies with the Americans with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, we do allow working service dogs to accompany our patients.

Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA. The Department of Justice has stated that emotional support animals are not protected as service animals under these regulations.

Should you arrive to an appointment with a pet that is not a service animal, you will be asked to reschedule your appointment. To avoid any disruption or inconvenience, we ask that you please leave your pet at home.

Thank you for your cooperation and consideration of all our patients.

_____ Date _____

Patient Signature

_____ Date _____

Witness Signature